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MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations

Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD 
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SUBJECT: Implementation Update #42: Community Support Definition Revision, Community Support Service 15/25% Qualified Professional Service Requirement, Comprehensive Service Provider, ValueOptions Liaison, ValueOptions Web Portal - Provider Connect, Intensive In-Home Service, Using the Wrong Provider Number to Authorize Services, Cost Reports, CAP-MR/DD: Plan of Care Submission to ValueOptions, Clarification Regarding Six Month Authorization, Development of Tiered Waivers, Supports Intensity Scale Pilot

Community Support Definition Revision

Effective March 1st, the revised Community Support definition was implemented. In essence the changes are designed to increase overall understanding of the components of Community Support, increase understanding of who is eligible for Community Support and provide a framework for understanding when, where, and how this service is implemented.

Highlights of the revised definition include:

- Emphasizes the treatment and rehabilitation components of the definition
- Clarifies the role and duties of the Qualified Professional and the Associate/Para-Professional
- Establishes a *minimum* 15% Qualified Professional service provision requirement for each individual served and a 25% minimum of Qualified Professional service provision at the aggregate provider level, thus expecting that providers serve consumers of varying acuity levels
- Emphasizes the requirement of the clinical assessment to support the Person Centered Plan (PCP) and that the PCP drives the delivery of Community Support
- Clarifies what interventions are billable as Community Support

- Notifies the provider of the expectation to refer to other appropriate services and providers in order to provide the most appropriate treatment service to the recipient
- Refines the entrance, continued stay and discharge criteria
- Requires the interventions and the PCP to be based on acceptable community standards and treatment practices such as American Academy of Child and Adolescent Psychiatry and American Psychiatric Association Practice Guidelines
- Maintains the adult benefit limitation of 780 units in 90 days

Community Support is a clinical, treatment service determined AFTER the appropriate assessment(s) is completed and the mental health or substance abuse challenges/problems identified. Due to the therapeutic intent of the service and the necessary discussion of treatment options, this service is to be offered in the context of a comprehensive treatment plan upon the identification of qualifying diagnoses. Direct recruitment of consumers or recipients with the intent of extending a specific service, prior to the reliable identification of a definitive need for that service, is considered inappropriate. **10A NCAC 27G .0205** *Assessment and Treatment/Habilitation or Service Plan, and Client Rights Rules in Community MH/DD/SA Facilities* provides regulatory guidance on the requirements for an appropriate assessment. A professional code of ethics is implicit in one's enrollment as a Medicaid provider; failure to operate in such a manner warrants prompt action and will be dealt with accordingly.

Community Support Service 15/25% Qualified Professional Service Requirements

There have been many questions relating to how the qualified professional service provision percentage requirements should be calculated. Of the total time billed for each consumer, 15% of that billed time is the absolute minimum percentage of time a Qualified Professional (QP) should be contributing to the consumer's service provision. However, the intent of the Community Support service is that on average a QP will contribute at least 25% of the billable time to service provision for each consumer on their caseload. Thus, the minimum 15% would likely be reserved to consumers transitioning out of care or who are receiving some minimal services to maintain a level of functioning already achieved. These cases would balance against those that are new or that are high risk cases that may receive as much as 40 to 50% of QP time. Thus, the 25% is the minimum average percentage of time that all QP's at a site contribute to service provision with all consumers receiving community support services.

Thus, there are two levels of monitoring of QP time that providers of Community Support (CS) services should develop in order to adequately monitor compliance with the 15/25% requirement. The first level is to ensure that each CS consumer receives the *minimum* level of 15% of QP time of the total billable CS services within an authorization time period. For example, if the service was authorized for 90 days and within those 90 days 80 hours of CS was billed, at *least* 12 hours should be provided by and billed as QP time.

The second level of monitoring is at the site level for all consumers receiving CS services. The second level is to ensure that the total amount of CS services **billed and paid** for all consumers at a site within any given month equals at least 25% QP time. So, if a provider bills and is paid for 250 hours of CS during the month of May, 2008, at least 62.5 hours should be billed and paid as H0036H"X"U3 and provided by a QP. [Note: The "X" in the billing code would actually be billed as A for child, B for adult or Q for group.]

Local Management Entities (LMEs) will begin monitoring the 25% requirement effective with services **paid in May, 2008**. The LME will notify any providers whose CS paid claims during a month do not meet the 25% threshold. If a provider site falls below the 25% requirement for two months in a row, the endorsement to provide CS at that site **will be** withdrawn.

Comprehensive Service Provider

In Implementation Update #41 proposed standards for a Comprehensive Service Provider was introduced. This initiative was a part of the Secretary's Community Support Plan to ensure provider agencies have the capacity to provide quality services to recipients of Community Support Services. After reviewing the comments received in response to the proposed standards several themes emerged. There is significant support within the provider community to raise the quality and expectations of service provision. However, the standards as they were originally proposed require further study and additional time for implementation.

In response to this feedback, we will not be implementing the Comprehensive Service Provider standards at this time. However, we will be setting benchmarks related to the existing requirement that agencies obtain national accreditation within three years of enrollment of providing Community Intervention Services. Benchmarks are based on the latest dates by which providers may establish official intent with an accrediting agency in order to successfully complete the accreditation process by March 20, 2009. The March 20, 2009 date is applicable to agencies that were enrolled on March 20, 2006 to provide Community Intervention Services. There are four approved accrediting agencies, the Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Council on Quality and Leadership (CQL), and the Joint Commission on Accreditation of Healthcare Organizations (JACHO); the dates are as follows:

CARF: July 31, 2008
COA: March 1, 2008
CQL: September 1, 2008
JACHO: September 1, 2008

Further information about the accrediting agencies can be found in Communication Bulletin #50: <http://www.ncdhhs.gov/mhddsas/announce/commbulletins/commbulletin050accreditation.pdf> and in Implementation Update #39: <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-6-08update39.pdf>

The national accreditation standard authority is in the State Plan Amendment (SPA) approved by the Center for Medicaid and Medicare Services (CMMS). The following benchmarks will be applied to agencies that were enrolled with DMA to provide Community Intervention Services as of March 20, 2006. All communication relating to accreditation should be between DMH/DD/SAS, the provider and the LME that granted corporate verification to the provider.

March 31, 2008: DMH/DD/SAS and DMA have identified providers that were enrolled as of March 20, 2006. This information will be provided to Local Management Entities (LME's).

May 1, 2008: Identified provider agencies will be required to inform the LME which accrediting body they have selected.

July 31, 2008: Identified provider agencies must submit evidence of official intent with one of the four accrediting agencies. This documentation must include acknowledgement from the accrediting agency on the accrediting agency's letterhead. Documentation should be submitted to the LME. Identified providers not able to meet this deadline will be required to begin addressing consumer needs by working with all LMEs in the catchment area(s) in which they provide services to develop a transition plan of current consumer caseloads.

August 1, 2008: LME's will submit to DMH/DD/SAS identified providers that did not submit the required documentation. The Division will provide public access to this information by creating a database on their website. LME's should review this database; any identified provider within their catchments area should be removed as a provider option when presenting provider choice to new consumers. Consumer and Family Advisory Committees (CFAC) and other consumer advocates should encourage consumers to seek out providers that will be eligible for continuous service provision.

January 1, 2009: Any remaining identified provider agencies that have continued to provide services to consumers must submit a transition plan for remaining consumers served to the LME no later than January 1, 2009. Value Options will not provide any new authorizations for any consumer that is still being served by a provider agency not eligible for accreditation.

March 20, 2009: All consumer transition plans complete and identified provider agencies not accredited will have their Medicaid enrollment terminated.

These benchmarks will further support providers pursuing national accreditation while protecting consumers from a disruption of service if they have been receiving services from a provider that cannot meet the national accreditation quality requirements.

ValueOptions Liaison

Each LME has identified a liaison to network with ValueOptions regarding all out of state placements, complex cases such as those with multiple diagnoses, cases involved with juvenile justice, and adults requesting over 780 units of CS in 90 days. The LMEs will also receive copies of letters recommending alternative services instead of the service originally requested so that the LME will know the volume of recommendations to aid the development of appropriate provider capacity.

ValueOptions Web Portal - Provider Connect

Providers of Community Support services are encouraged to begin submitting requests for Community Support to ValueOptions via its web portal Provider Connect rather than by fax. On line submission of requests allows instant confirmation of the receipt of the request as well as real time checks of certain data elements. Providers are encouraged to email PSDProviderRelations@valueoptions.com to sign up for a web cast training in order to begin using Provider Connect. Adoption of the simple steps covered in the training is essential for effective and continued use of the provider web site.

Intensive In Home Services (IIH)

Although the IIH service is authorized for one individual child in the family, IIH services are intended to be a service with a team approach for the entire family. Under no circumstances should a provider submit requests for IIH services for more than one child in the home. There have been occurrences where independent requests, using a separate In Patient Treatment Report (ITR) and PCP have been submitted for IIH authorization. This practice must cease immediately. If a provider has been paid for delivering IIH services to more than one child in the family currently, it will result in a payback situation.

Using the Wrong Provider Number to Request Services

In recent months there have been providers contacting ValueOptions and asking for a provider number to be changed on an authorization already in place. There have been a variety of reasons for these requests. However, as all providers should know:

- It is never acceptable to request or bill for services under a number other than the one where services are delivered. This violates the MOA with the LME and the provider's contract with DMA since provider numbers are site specific.
- For example, this means if you have a Wake County office and a Durham County office these numbers are not interchangeable. This is not acceptable even in circumstances when the provider has applied for a new site number and has not received it yet.

After June 1, 2008, ValueOptions will be directed not to make changes of this nature for past authorization requests. They will enter an authorization to a new number at the next request for services. The provider cannot be reimbursed for services authorized or billed to the wrong provider number.

Cost Reports

We are reminding all providers receiving Medicaid funds for mental health services, who have a fiscal year ending on or after 12/31/07 that they are required to file the Mental Health Cost Report. The due date in this first reporting year is 5 months after the year end closing date (i.e. a 12/31/07 fiscal year end translates into a cost report due on or before 5/31/08). This will apply to Residential Treatment providers in subsequent reporting periods after 12/31/07 and CAP-MR/DD providers with a fiscal year ending after June 30, 2007.

In order to accomplish the reporting described above, private providers will report their 12 months of accumulated costs, supported by their audits or financial statements as of year end 12/31/07 or any date thereafter. Because employee time data will only have been tracked for a period of less than 12 months, starting as of 7/1/07, the time data will need to be annualized.

The information above reflects a change to cost reporting requirements for providers of CAP-MR/DD & Residential Treatment. In an effort to consolidate and decrease the number of cost reports required of a single provider, the Division of Medical Assistance will no longer require separate cost reports from CAP- MR/DD or Residential Treatment Providers.

All CAP-MR/DD providers with a fiscal year ending after June 30, 2007 and all Residential Treatment providers with a fiscal year ending after December 31, 2007 will be required to file the Mental Health Cost Report administered by the DHHS office of the Controller.

Providers will no longer be granted exemptions based on the amount of Medicaid revenue received or the number of months in business. If a provider has received an exemption for a current cost report period, the exemption will be allowed for that cost report period only. The Residential Treatment Cost Reports scheduled to be received at DMA by May 31, 2008 are still required as previously published.

Information regarding the Mental Health Cost Report, including training, will be forthcoming and posted to the DHHS Controller's office Website <http://www.ncdhhs.gov/control/amh/amhauth.htm>.

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD)

Plan of Care Submission to ValueOptions

Per the CAP-MR/DD manual page 13, in order for the CAP-MR/DD Plan of Care to meet the requirement for clinical review and authorization, "...the Plan of Care must clearly address needs related to health and safety as well as how they will be addressed. This includes crisis planning, both proactive and reactive, as well as identified back up staff in case of emergencies." It is not sufficient to note that the only crisis plan for an individual is to call 911. The crisis plan can be documented within the Plan of Care or as a stand alone document attached to the Plan of Care. The crisis plan component of the Plan of Care should clearly detail the process to prevent a pending crisis, in addition to the steps to be followed in the event a crisis cannot be avoided. This information should include the specific interventions, responsible person(s), and contact information of those involved. The use of 911 should only be used when all other interventions have been exhausted and unsuccessful or in the event of a medical emergency.

Additionally, per the CAP-MR/DD manual section 3.6.4, the information required for an *Initial Plan of Care Approval* includes the following:

- Contact information for the case manager
- Plan of Care including the cost summary
- MR2 including LME, physician or licensed psychologist signature
- Current psychological evaluation
- North Carolina Supports Needs Assessment Profile (NC-SNAP)

At the time of the Continued Need Review (CNR) the following information is required for authorization:

- Contact information for the case manager
- Plan of Care including the cost summary
- MR2 including qualified professional, physician or licensed psychologist signature
- NC- SNAP

Please note that the full NC-SNAP is required for authorization, not just the face sheet. The additional rating information is critical to assessing the level of supports and services needed by the individual and **MUST** be provided as a comprehensive document. If the required information is not provided at the time of the Plan of Care submission for approval, additional requests for the information will be made resulting in additional delay of the approval of the plan.

Clarification Regarding the Six Month Authorization

There have been many questions about the issue of what services require authorization every six months. All CAP-MR/DD services **except** Targeted Case Management require authorization every six months. The **only service** not required to be authorized every six months is Targeted Case Management. All other CAP-MR/DD services must be authorized every six months according to medical necessity requirements in order to receive payment.

Development of the Tiered Waivers

The DMH/DD/SAS and DMA are pleased to announce public forums to provide information regarding the CAP-MR/DD tiered waivers. This is an opportunity for stakeholders to learn more about the proposed tiered waivers and provide feedback. The public forums are scheduled as follows:

- **May 6, 2008 at Cherry Hospital Therapeutic Center Auditorium, 201 Stevens Mill Road, Goldsboro, NC.** Two repeating sessions (same information provided at both sessions). The first session is from 11 a.m. to 1 p.m.; the second session is from 6 p.m. to 8 p.m.
- **May 16, 2008 at Broughton Hospital located at 1000 South Sterling St., Morganton, NC.** Two repeating sessions (same information provided at both sessions). The first session is from 11 a.m. to 1 p.m.; the second session is from 6 p.m. to 8 p.m.
- **May 20, 2008 at CenterPoint LME Auditorium located at Behavioral Health Plaza, 725 N. Highland Ave Winston Salem, NC.** There will be two repeating sessions (same information provided at both sessions). The first session is from 11 a.m. to 1 p.m.; the second session is from 6 p.m. to 8 p.m.

Additional information regarding locations and directions will be announced on the DMH-DD-SAS website:

<http://www.ncdhhs.gov/mhddsas/>.

Supports Intensity Scale Pilot

The Supports Intensity Scale (SIS) is an assessment tool that measures practical support requirements of an individual with an intellectual disability. Unlike traditional assessments, the SIS focuses on what daily supports an individual needs to live as independently as possible within their community. It was developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) formerly known as American Association of Mental Retardation (AAMR). The SIS is a reliable tool and is the product of research and design. It is in use by ten other states.

The SIS measures the intensity of supports a person needs but does not replace the NC-SNAP. The SIS assessment is completed through an interview in which the individual and at least two respondents who know the person well enough to comment on the person's ability to complete activities in seven life domains and measures the level of assistance and support that is needed to be successful at those activities. The information gathered and learned during the assessment process will be used to enhance the Person Centered Planning process. For additional information please visit the SIS website: <http://www.siswebsite.org/>.

At this time the seven LMEs with single stream funding will implement the Supports Intensity Scale as a pilot project with the DMH/DD/SAS. The seven LMEs that are participating in the current project include: East Carolina Behavioral Health, Five County, Durham, Guilford, Sandhills, Mecklenburg, and Smoky. The DMH/DD/SAS is working with these LMEs to

providing training with the case management agencies who will be involved in the project. The project will provide the SIS assessments to a limited number of individuals over the next several months. This project is an effort to determine the best processes needed to implement the use of the SIS on a statewide basis over the next several years with individuals who are receiving CAP-MR/DD funding.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

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